Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THOMAS DILGER MD

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-14-1026-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 04, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 1/14/13. Despite multiple attempts to collect on this claim, the insurance carrier is attempting theft of services rendered. The DDE & caim were faxed to the carrier on 1/14/13. Therefore, MDR is filed via certified mail with receipt."

Amount in Dispute: $850.00 + interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Gallagher Bassett escalated the claim in question for date of service 01/14/13 for further review by the bill audit company. The medical provider is alleging that they are owed payment in full which is $850.00

As a result of our review, we have issued payment as follows:

$675.00 issued on 1/1/2014

$19.39 issued on 1/14/14 for interest owed.

Our bill bill review vendors position is that the bill is not owed in full and this is the rationale supporting this position:

10/16/12 26123351473600

99456/RE.W6.RM allowed at billed charge $500 – First exam

99456 $350 base value, $500 RE, $300 RM

1/14/13 26133611415000

99456/RE.W8.RM

$350 base value, $150 RE, $150 RM = $650 x 50% = $325

99456/NM.W5.RM - $350 (NM) + 150(RM) =$500.00 – line allowed at billed charge $350 correct."

Response Submitted by: Gallagher Basset Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2013	CPT Code 99456-NM-W5 and 99456-RE-W8	$650.00 + interest	$180.45

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out the procedures for Medical Payments and Denials.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
5. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
6. Texas Labor Code §401.023 sets out the procedures for Interest or Discount Rate.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - No explanation of benefits provided by the requestor

Issues

1. What is the maximum allowable reimbursement for CPT Code 99456-NM-W5 and 99456-RE-W8?
2. Is the requestor entitled to reimbursement for interest accrued for disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(2)(A)(3)(C) states "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." In order for the requestor to reimbursed in accordance with 28 Texas Administrative Code §134.204(j)(2)(A)(3)(C), the requestor in this case was required to perform a maximum medical improvement examination. Review of submitted documentation provided supports a maximum medical improvement examination performed on January 14, 2013; however the injured employee did not reach maximum medical improvement on the date the examination was performed. The reimbursement for CPT Code 99456NM-W5 is $350.00

   Per 28 Texas Administrative Code §134.204(k) states "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(k), the requestor in this case was required to perform a return to work evaluation. Review of submitted documentation finds the requestor performed a return to work evaluation for disputed service January 14, 2013. Reimbursement for disputed service CPT Code 99456-RE-W8 is $500.00.

   The total maximum allowable reimbursement is $850.00 for CPT Code 99456-NM-W5 and 99456-RE-W8.

   The respondent provided payment information in the DWC-60 response indicating payment issued for CPT Code 99456-NM-W5 in the amount of $350.00 and $325.00 for CPT Code 99456-W6 for service date January 14, 2013.
2. Per 28 Texas Administrative Code §134.130 reimbursement amount allowed is 24.84. Documentation provided by the respondent indicates payment made in the amount of $19.39.
3. The division concludes that the total allowable for CPT Code 99456NM-W5 and 99456-RE-W8 is $850.00 and $24.84 for interest. The respondent issued payment in the amount of $675.00 for CPT Code 99456NM-W5 and 99456-RE-W8 and $19.39 for interest. Based upon the submitted documentation, additional reimbursement in the amount of $175.00 is due for CPT Code 99456-RE-W8 plus $5.45 for interest is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $180.45.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $180.45 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/26/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.